BEFORE THE STATE BOARD OF REGISTRATION FOR THE HEALING ARTS

STATE BOARD OF REGISTRATION FOR THE HEALING ARTS,	)	
Board,	)	
v.	)	Case No. 2003-005376
RONALD GASKIN, M.D.,	)	
Licensee.	)	

SETTLEMENT AGREEMENT

Comes now Ronald Gaskin, M.D., (Licensee) and the State Board of Registration for the Healing Arts (the Board) and enter into this Agreement for the purpose of resolving the question of whether Gaskin's license as a physician or surgeon will be subject to discipline. Licensee and the Board jointly stipulate and agree that a final disposition of this matter may be effectuated as described below pursuant to §621.045, RSMo.

1. Licensee acknowledges that he understands the various rights and privileges afforded by law, including the right to a hearing of the charges against Licensee; the right to appear and be represented by legal counsel; the right to have all charges against Licensee proven upon the record by competent and substantial evidence; the right to cross-examine any witnesses appearing at the hearing against Licensee; the right to present evidence on Licensee's own behalf; the right to a decision based upon the record

by a fair and impartial administrative hearing commissioner concerning the charges pending against Licensee; and subsequently, the right to a disciplinary hearing before the Board at which time evidence may be presented in mitigation of discipline. Having been advised of these rights provided Licensee by operation of law, Licensee knowingly and voluntarily waives each and every one of these rights and freely enters into this Agreement and agrees to abide by the terms of this document as they pertain to Licensee.

2. Licensee acknowledges that he may, at the time this Agreement is effective or within fifteen days thereafter, submit this Agreement to the Administrative Hearing Commission for determination that the facts agreed to by the parties constitutes grounds for discipline of Licensee's license.

3. Licensee acknowledges that he has been informed of his right to consult legal counsel in this matter.

4. The parties stipulate and agree that the disciplinary order agreed to by the Board and Licensee in Part II herein is based only on the Agreement set out in Part I herein. Licensee understands that the Board may take further disciplinary action against Licensee based on facts or conduct not specifically mentioned in this document that are either now known to the Board or may be discovered.

5. Licensee understands and agrees that the Missouri State Board of Registration for the Healing Arts will maintain this Agreement as an open record of the Board as required by Chapters 334, 610, 620 and 621, RSMo, as amended.

6. Licensee acknowledges that he has received a copy of the investigative report and other documents relied upon by the Board in determining that there was cause for discipline, along with citations to law and/or regulations the Board believes was violated.

I.

Based upon the foregoing, Board and Licensee herein jointly stipulate to the following:

JOINT PROPOSED FINDINGS OF FACT

1. The State Board of Registration for the Healing Arts ("the Board") is an agency of the State of Missouri created and established pursuant to § 334.120, for the purpose of executing and enforcing the provisions of Chapter 334, RSMo.

2. Licensee is licensed by the Board as a physician and surgeon, license number R4346, which was first issued on June 26, 1971. Licenee's certificate of registration is and was current and active at all times mentioned herein.

3. At all times relevant herein, Licensee practiced as a general surgeon in and around St. Louis, Missouri.

Count I – Patient L.G.

4. The Board realleges and incorporates paragraphs 1 through 3 as though fully set forth herein.

5. On or about November 20, 2001, Licensee admitted patient L.G. to St. Anthony's Medical Center ("St. Anthony's") in St. Louis, Missouri, in order to perform a laparoscopic cholecystectomy. (removal of the gallbladder)

6. L.G. was a 64-year-old female, with a diagnosis of biliary colic secondary to gallstones.

7. Prior to surgery, L.G. made Licensee aware that she would not accept transfusions of blood or blood products, due to her religious beliefs as a Jehova's Witness.

8. On November 20, 2001, Licensee performed a laparoscopic cholecystectomy on L.G.

9. During the course of the procedure, Licensee lacerated L.G.'s abdominal aorta.

10. In his operative note, Licensee estimated that L.G. lost approximately 1500 cc of blood during the procedure.

11. After Licensee lacerated L.G.'s aorta, Licensee converted the procedure to an open procedure.

12. Licensee performed an adequate repair of the lacerated aorta and L.G. did not continue to bleed. However, the original estimate of blood loss was too low. L.G. suffered from severe anemia, low hemoglobin, and reduced blood pressure as a result of the intra-abdominal bleeding during the surgery.

13. Early in the morning of November 21, 2001, L.G. became unresponsive and her blood pressure dropped. St. Anthony's staff concluded that L.G. had suffered severe brain damage due to blood loss.

14. L.G. was pronounced dead at 11:12 a.m. on November 21, 2001.

15. Licensee charted the cause of death as "hypotension secondary to blood loss."

16. On November 21, 2001, the Medical Executive Committee at St. Anthony's summarily suspended Licensee's laparoscopic surgical privileges at St. Anthony's pending an investigation regarding the aortic laceration and subsequent death of L.G.

17. On October 14, 2002, the Hearing Committee at St. Anthony's recommended that Licensee's laparoscopic surgical privileges remain suspended until Licensee completed two hands-on laparoscopic cholecystectomy courses approved by St. Anthony's. Upon completion of the courses, Licensee next 25 laparoscopic procedures at St. Anthony's were to be attended by a proctor and reviewed by the staff.

18. On January 8, 2003, Licensee resigned from the staff of St. Anthony's and surrendered his privileges, retroactive to December 31, 2002.

Count II – Patient R.M.

19. The Board realleges and incorporates paragraphs 1 through 18 as though fully set forth herein.

20. On or about November 4, 1999, Licensee was called in to consult on the case of patient R.M., who had been admitted to Forest Park Hospital ("Forest Park") in St. Louis, Missouri.

21. R.M. was a 59-year-old female with a diagnosis of cholecystitis (inflammation of the gallbladder) and cholelithiasis (gallstones).

22. On or about November 4, 1999, Licensee performed a laparoscopic cholecystectomy.

23. R.M. had an aberrant anatomy, in that the R.M.'s cystic duct (the duct that carries bile away from the gallbladder) was shorter than usual.

24. During the course of the procedure, Licensee attempted to clamp off the cystic duct, but instead clamped off the common duct.

25. The cystic duct and the hepatic duct (which carries bile from the liver) join to form the common duct.

26. By clamping off the common duct, Licensee also prevented bile from draining from R.M.'s liver.

27. As a result of Licensee's clamping off the common duct, R.M. developed a major complication postoperatively. Specifically, bile began leaking into her abdomen.

28. Licensee was transferred from Forest Park to another facility for further care, and required further surgery as a result of Licensee's misidentification of R.M.'s anatomy and clamping of the common duct.

Count III – Patient L.S.

29. The Board realleges and incorporates paragraphs 1 through 28 as though fully set forth herein.

30. Prior to April 12, 2001, Patient L.S. was referred to Licensee for gastric bypass surgery.

31. Patient L.S. was a 50-year-old, morbidly obese female. L.S. has been unable to control her obesity despite repeated attempts at dieting.

32. On April 12, 2001, Licensee performed a "Roux-en-Y" gastric bypass procedure on Patient L.S. During the April 12, 2001 procedure, Licensee isolated a small section of the patient's stomach and attached a portion of the patient's upper small intestine directly to the pouch formed from the small section of stomach. Licensee also removed a small nodule from the patient's liver.

33. On April 17, 2001, L.S. developed a perforation in the gastric pouch that was created from L.S.' stomach during the gastric bypass procedure done on April 12, 2001, allowing gastric contents to leak into the abdomen.

34. Following the April 12, 2001 procedure, L.S. complained of abdominal pain.

35. On or about April 13 and 14, 2001, L.S.' abdominal dressings were observed to be soaked with an excessive amount of blood.

36. As a result of the perforated gastric pouch, L.S. became septic.

37. Licensee failed to timely diagnose or treat L.S.' postoperative sepsis.

38. Licensee performed surgery to repair the perforation on the evening of April 17, 2001. During the procedure, two to three liters of accumulated blood were drained from L.S.' abdomen.

39. L.S. expired from postoperative sepsis on April 18, 2001.

JOINT PROPOSED CONCLUSIONS OF LAW

1. Based on the foregoing, Licensee's license is subject to disciplinary action pursuant to § 334.100.2(4)(g) and (5), RSMo 2000, which provides:

> 2. The board may cause a complaint to be filed with the administrative hearing commission as provided by chapter 621, RSMo, against any holder of any certificate of registration or authority, permit or license required by this chapter or any person who has failed to renew or has surrendered his certificate of registration or authority, permit or license for any one or any combination of the following causes:
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> (4) Misconduct, fraud, misrepresentation, dishonesty, unethical conduct or unprofessional conduct in the performance of the functions or duties of any profession licensed or regulated by this chapter, including, but not limited to, the following:
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> (g) Final disciplinary action by any professional medical or osteopathic association or society or licensed hospital or medical staff of such hospital in this or any other state or territory, whether agreed to voluntarily or not, and including, but not limited to, any removal, suspension,

limitation, or restriction of his license or staff or hospital privileges, failure to renew such privileges or license for cause, or other final disciplinary action, if the action was in any way related to unprofessional conduct, professional incompetence, malpractice or any other violation of any provision of this chapter;

* * * *

(5) Any conduct or practice which is or might be harmful or dangerous to the mental or physical health of a patient or the public; or incompetency, gross negligence or repeated negligence in the performance of the functions or duties of any profession licensed or regulated by this chapter. For the purposes of this subdivision, **"repeated negligence"** means the failure, on more than one occasion, to use that degree of skill and learning ordinarily used under the same or similar circumstances by the member of the applicant's or licensee's profession;

* * * *

2. Licensee's conduct, as established by the foregoing facts, falls within the intendments of § 334.100.2(4)(g) and (5), RSMo 2000.

3. Cause exists for Board to take disciplinary action against Licensees' licenses under Section 334.100.2(4)(g) and (5), RSMo 2000.

II.

Based on the foregoing, the parties mutually agree and stipulate that the following shall constitute the disciplinary order entered by the State Board of Registration for the Healing Arts in this matter under the authority of Section 621.110, RSMo 1994. This Agreement will be effective immediately on the date entered and finalized by the Board.

A. Effective the date the Board enters into the Agreement:

1. The medical license, No. R4346, issued to Licensee is hereby restricted or limited in the practice of medicine until modified or lifted by action of this Board (the "disciplinary period") as follows:

a. Licensee will cease performance of laparoscopic cholecystectomies indefinitely or until said restriction is modified or lifted by action of this Board.

b. Licensee will cease performance of gastric bypass surgeries indefinitely or until said restriction is modified or lifted by action of this Board.

B. Licensee hereby waives and releases the Board, its members and any of its employees, agents, or attorneys, including any former Board members, employees, agents, and attorneys, of, or from, any liability, claim, actions, causes of action, fees costs and expenses, and compensation, including, but not limited to any claims for attorneys fees and expenses, including any claims pursuant to §536.087, RSMo, or any claim arising under 42 USC 1983, which may be based upon, arise out of, or relate to any of the matters raised in this agreement, or from the negotiation or execution of this agreement. The parties acknowledge that this paragraph is severable from the remaining portions of this agreement in that it survives in perpetuity even in the event that any court of law deems this agreement or any portion thereof void or unenforceable.

C. In consideration of the foregoing, the parties consent to the termination of any further proceedings based upon the facts set forth herein.

LICENSEE

Ronald Gaskin, M.D. date 11/6/06

BOARD

Tina Steinman date 11/21/06
Executive Director

JEREMIAH W. (JAY) NIXON
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Attorneys for Board

EFFECTIVE THIS 22 DAY OF November, 2006.